STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814

January 31, 1985

ALL-COUNTY LETTER NO. 85-16

TO: ALL-COUNTY WELFARE DIRECTORS

SUBJECT: REVISED MONTHLY ELIGIBILITY REPORT CA 7 (3/85) VERSION

The purpose of this letter is to provide you with an advance copy of the final English version of the revised CA 7 (3/85). This revision is limited to the change necessary to include the specific Food Stamp Program disqualification penalties for intentional Program violation(s).

The implementation date of this form for all counties is June 1, 1985. The first (3/85) CA 7 will be due in June for the budget month of May. However, any county printing its own supply of the form may begin using the (3/85) CA 7 earlier if stock of the current version (9/84) is depleted prior to the June 1 implementation date. The attached copy may be used as a master. Spanish masters will be distributed to the counties as soon as they are available.

Supplies of the state printed English and Spanish version of the (3/85) CA 7 will be available the week of April 15, 1985. Orders should be submitted the week of April 1 on the GEN 727B, County Forms Order, according to normal procedures. To ensure that orders for the revised forms are not filled with the (9/84) version, please specify the (3/85) revision date on the order form.

Also scheduled for a June 1, 1985 implementation is a revised DFA 285 A-2, which will include the specific Food Stamp Program disqualification penalties for intentional Program violations. More specific information on this revision will be sent in March 1985.

Should you have any questions, please contact the Food Stamp Policy Implementation Bureau at (916) 445-6907 or your AFDC Program Management Consultant at (916) 322-5330.

ROBERT A. HOREL
Deputy Director

cc: CWDA

Attachment

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

MONTHLY ELIGIBILITY REPORT

For Cash Aid and Food Stamps

THIS REPORT IS FOR THE MONTH OF:

Complete, sign, date and return this form AFTER the last day of:

- You must complete this report and return it by the **5th** of the month. If this report is not received by the **11th** of the month or is incomplete, your Cash Aid, Cash-based Medi-Cal and/or Food Stamps may be delayed, decreased or discontinued.
- If you do not **ATTACH** proof of reported income, your benefits may be discontinued. If you do not **ATTACH** proof of expenses, your benefits may be decreased or discontinued.
- **Call your worker if you need help completing the form.** Attach a separate sheet of paper if needed.

Worker: Phone:

NOTE: If you or your family no longer want Cash Aid, Medi-Cal or Food Stamps check this box ☐, state the reason and type(s) of assistance no longer wanted, complete the signature block and return the form by the due date.

Reason and Type(s) of assistance:

If you receive cash aid or food stamps, answer ① through ⑨. Answer for everyone in your household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in your home.

① **Did anyone receive income, money, or benefits in the month,** such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment/disability insurance, interest, worker's compensation, SSI/SSP (gold checks), child/spousal support, loans, grants, tax refund, cash, gifts, free housing/utilities, etc.? ☐ **YES** ☐ **NO**

If **YES,** complete section below. **ATTACH PAYSTUBS** or other proof of earnings each month. **ATTACH PROOF** for any other income only when it starts and when it changes. If anyone is self-employed, list business expenses on a separate sheet of paper and **ATTACH PROOF** of income and expenses each month. **(If you receive cash aid and you fail to report or ATTACH PROOF of earned income by the 11th of the month, the standard work expense, dependent care, and when eligible for it, the $30 and 1/3 disregard will not be allowed.)**

Who Received Income, Money or Benefits?	Source (If Earnings, List Name of Employer)	Enter below dollar amounts and actual dates received. If earnings, enter gross amount before deductions.					If Earnings: Number of Days Worked in Month	If Earnings: Number of Hours Worked in Month
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		

② **Did anyone pay for the care of a child or disabled adult so that someone in the home could go to work, training or look for a job?** ☐ **YES** ☐ **NO**

If **YES,** complete below and **ATTACH** a receipt for each person receiving care.

Who Received Care?	Cost of Care	Who Received Care?	Cost of Care
	$		$
	$		$

		YES	NO
③	**Did anyone move into your home (including a new born), move out, get married, or die?**	☐	☐
④	**Did anyone become disabled or recover from a disability?**	☐	☐
⑤	**Did anyone start, refuse, lose, quit or change a job/training, or go on strike?**	☐	☐
⑥	**Did anyone start, stop or change school or college?**	☐	☐
⑦	**Did anyone receive, buy, sell or give away any property such as a house, land, motor vehicle, camper, boat, etc.?**	☐	☐

If **YES,** to any of the changes, give name of person, date of change and explain the change. If property change, give value of item.

COUNTY USE ONLY **E.W. INITIALS** **DATE:**

(8) **Did anyone have a checking, savings or credit u. account open at the end of the month?** ☐ YES ☐ NO

If **YES**, complete below.

☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month	Whose Account?	☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month	Whose Account?

(9) **Did you move, or do you have a new mailing address or phone number?** ☐ YES ☐ NO

If **YES**, complete below.

Home Address (Number, Street Name, Avenue Blvd. Etc.)	Apt. No.	City	State	Zip Code	Phone No.

Mailing Address (If Different Than Home Address)	City	State	Zip Code

If you receive food stamps, answer (10) through (13) for everyone in your household. If you do not receive food stamps, go to (14) through (17).

(10) **Did the household have housing costs?** ☐ YES ☐ NO

If **YES**, enter amount billed.

ATTACH bills only if you moved or the cost changed.

Rent or Mortgage	Property Taxes or Insurance (if not in mortgage)
$	$

(11) **Did the household have utility costs?** ☐ YES ☐ NO

If **YES**, and you moved or claim actual utility costs, complete below and **ATTACH BILLS.**

Gas/Fuel	Electricity	Telephone	Utility Installation	Garbage/Trash	Water	Sewage	Other (Specify)
$	$	$	$	$	$	$	$

(12) **Did the household share housing or utilities or did anyone help pay these costs?** ☐ YES ☐ NO

If **YES**, list each item, amount paid, who paid and **ATTACH PROOF.**

(13) **Did anyone who is disabled or age 60 or older have any medical expenses in the month?** ☐ YES ☐ NO

If **YES**, complete below and **ATTACH BILLS** for each expense.

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
		$			$

If you receive cash aid, answer (14) through (17) for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home. If you do not receive cash aid go to (17).

(14) **Did you or anyone in your family who received income pay any court ordered support in the month?** ☐ YES ☐ NO

If **YES**, enter the amount paid and **ATTACH RECEIPTS:** $

(15) **Did anyone start, stop or change health or hospitalization insurance coverage such as Prudential, Blue Cross, Champus, etc.?** ☐ YES ☐ NO

If YES, give name of person, date and explain change.

(16) **Did anyone become pregnant, ha. a baby or terminate a pregnancy?** ☐ YES ☐ NO

If YES, give name of person, date and explain change.

If you receive cash aid or food stamps, answer (17). Answer for everyone in the household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home.

(17) **Does anyone in the home have other information to report for this month or next month,** such as: recent or expected changes in income, place of employment, number of working hours or days per week, place of residence, property, persons in the household, etc? ☐ YES ☐ NO

If **YES**, explain the change, if it is expected to be temporary or permanent and indicate the date of the change.

CERTIFICATION

- ***I understand that failing to report information or misrepresentation of facts for Cash Aid programs, Food Stamps or Cash-based Medi-Cal can result in legal prosecution with penalties of a fine, imprisonment or both. In the Food Stamp Program the penalties can result in permanent disqualification from the Program, fines up to $10,000 or imprisonment for up to 5 years. Disqualification penalties for Intentional Program Violation(s) are 6 months for the first violation, 12 months for the second violation, and permanent disqualification for the third violation.***
- *I understand that I must contact my worker to report any unexpected changes which affect my eligibility for or the amount of my Cash Aid within 5 days of the occurrence or if I have any doubt about needing to report any changes.*
- *I understand that reported information may result in a decrease or discontinuance of benefits.*
- *I understand I have the right to request a state hearing on any proposed action by the county welfare department.*
- ***I declare under penalty of perjury that the information contained in this report is true and correct and is complete for the entire report month.***

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE

For Cash Aid programs, you and your aided spouse (or the other parent of aided children) living in the home must sign the form. For the Food Stamp Program, the head of household, a household member or the household's authorized representative must sign the form.

Signature of Cash Aid Parent or Caretaker Relative and/or Food Stamp Household Member ▶	COUNTY WHERE SIGNED	Date Signed
Signature of Cash Aided Spouse or Other Parent of Cash Aided Children ▶	COUNTY WHERE SIGNED	Date Signed
Signature of Witness to Mark, Interpreter, or Other Person Completing Form ▶		Date Signed